

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040074  
5462 STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED OCT 24 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in lb <b>33 yrs.</b>		Inside Limits <b>Yes</b> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5004 E. 40th Terr.</b>		d. STREET ADDRESS (If outside, give location) <b>5004 E. 40th Terr.</b>	
Reside on Farm <b>Yes</b> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>DANIEL BART O'CONNOR</b>			4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-9-1899</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Local Union</b>	11. BIRTHPLACE (City and state or country) <b>Plattsburg, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	--	---

13a. FATHER'S NAME <b>Michael P. O'Connor</b>	13b. MOTHER'S MAIDEN NAME <b>Hannah</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Jean Tennant</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	17. INFORMANT <b>Mrs. Jean Tennant</b>	Address <b>K. C. Mo. 5004 E. 40th Ter</b>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Hypertensive arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>5 weeks</b> <b>1 year</b>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour <b>10:00</b> a.m. p.m.	Month, Day, Year <b>Aug - 1963</b>	20f. CITY, TOWN, OR LOCATION <b>Plattsburg, Missouri</b>
--	------------------------------------	---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Plattsburg, Missouri</b>
--	--	---

21. I attended the deceased from <b>Aug - 1963</b> to <b>Oct 8 - 63</b> and last saw her alive on <b>Oct 4 - 63</b> Death occurred at <b>3:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>John T. Skinner MD</b>	(Degree or title)	22b. ADDRESS <b>1102 So and N. EMU</b>	22c. DATE SIGNED <b>10-9-63</b>
---	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-10-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Plattsburg Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Plattsburg, Missouri</b>
--	--------------------------------	--	--

24. FUNERAL DIRECTOR <b>Sheil Funeral Home, Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-9-63</b>	26. REGISTRAR'S SIGNATURE <b>Bessie Smith</b>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF  
John T. Skinner  
MEDICAL CERTIFICATION

DATE AMENDED

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

82

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas A. Phil

Licensed Embalmer No. 4954

P. O. Address K.P. Mc

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.